FIREWORKS INJURY REPORTING

State Form 51497 (R/ 5-06)
INDIANA STATE DEPARTMENT OF HEALTH

CONFIDENTIAL INFORMATION

INSTRUCTIONS: *1. Print information to ensure legibility.*
2. Fill in square (or check box) for appropriate choice.
3. Complete all items on the form.
4. Per PL 187, report must be completed within 5 business days after examination of the injury.

Section 1: Demographic Information on Injured Person

Date of Medical Evaluation: _____

Last Name: _____First Name: _____ MI: _____

Phone Number: (____) _____ - _____ Date of birth: _____ Age: _____

If child, name of parent/guardian *(Last, First, MI)*: _____

Street Address: _____

City / Town: _____ **State:** _____ **ZIP code:** _____ **County:** _____

Sex:	**Race *(check all that apply)***	**Ethnicity**
☐ Male	☐ White	☐ Hispanic or Latino
☐ Female	☐ Black or African American	☐ Not Hispanic or Latino
☐ Unknown	☐ Asian	
	☐ Native Hawaiian or Other Pacific Islander	
	☐ American Indian or Alaska Native	
	☐ Unknown	

Section 2—Site of Report: Hospital / Emergency Department / Physician Office / Surgical Center

☐ **Hospital Name:** _____
☐ **Hospital / Related Site:** ☐ **Emergency Department** ☐ **Urgent Care Center**
☐ **Ambulatory Surgical Center (Name):** _____
☐ **If reporting from a Health Care Provider Office, State Name of Practice:**
_____

Physician Name: _____

Contact through: ☐ **Email:** _____ ☐ **Office:** (____) _____ - _____

Street Address: _____

City / Town: _____ **State:** _____ **ZIP code:** _____ **County:** _____

(Person Reporting) Title: _____

Last Name: _____ First Name: _____

Phone Number: (____) _____ - _____ Email: _____

Name of Injured Person: _____

Section 3: Injury and Surrounding Circumstances

Body Part Involved *(check all involved)*

- ☐ Hand(s) / Finger
- ☐ Arm
- ☐ Eye(s)
- ☐ Face / Ears / Head
- ☐ Leg(s)
- ☐ Trunk
- ☐ Other

_____

Type of Injury *(check all involved)*

- ☐ Burn
  - ☐ 1st Degree ☐ 2nd Degree ☐ 3rd Degree
- ☐ Contusion / Laceration / Abrasion
- ☐ Puncture Wound
- ☐ Penetrating Foreign Body / Missile
- ☐ Sprain / Fracture
- ☐ Other

_____

Outcome *(check all that apply)*

- ☐ Death
- ☐ Evaluated in Emergency Department
  - ☐ Released to home
  - ☐ Admitted to hospital
  - ☐ Transferred to _____
- ☐ Evaluated in provider office
  - ☐ Released to home
  - ☐ Admitted to hospital *(specify hospital)* _____
  - ☐ Other *(specify)* _____

If hospitalized:

Date of admission:_____

Date of discharge: *(if available)* _____

Circumstances of Injury

Date of injury: _____

Time of injury:_____ ☐ AM ☐ PM

Locale of injury:

- ☐ **Private** home / yard / property
- ☐ Friend / neighbor / relative home / yard / property
- ☐ **Public** park / street / property
- ☐ School property
- ☐ Other (specify) _____

If eye injury:

- ☐ no eye protection
- ☐ eyeglasses or safety glasses
- ☐ contact lenses

Risk Factors at the time of injury

- ☐ Alcohol Consumption
  - ☐ By injured person
    - ☐ Within 3 hours of injury
    - ☐ Blood alcohol tested
    - ☐ Unknown
  - ☐ By other people at the scene
- ☐ If injured person is less than 18 years of age, was an adult present?
  - ☐ Yes
  - ☐ No
  - ☐ Unknown
- ☐ Injured person was a bystander

Type of Fireworks / Pyrotechnics

- ☐ Firecrackers
- ☐ Rockets (i.e., bottle rockets)
- ☐ Sparklers
- ☐ Twisters / "Jumping Jacks"
- ☐ Lighting gunpowder
- ☐ Homemade, altered device
- ☐ Aerial devices
- ☐ Other (fountains, roman candles, etc.)
- ☐ Pyrotechnics – state Event or Location involved _____
- ☐ Unspecified / Unknown

Mechanism / Problem *(if known)*

- ☐ Malfunction / timing of firework
- ☐ Errant path of rocket
- ☐ Debris from aerial fireworks
- ☐ Mishandling (relighting, throwing, etc.)
- ☐ Other
- ☐ Unknown

Comments / Additional Information

Please fax this form to (317) 233-7805: Attn: Injury Epidemiologist----phone (317) 233-7415

Or mail to: Indiana State Dept of Health
2 North Meridian Street, 6A
Indianapolis, IN 46204